# A Basis for Criticism

**comprising**

**A Simplified Understanding of the nature of Ideas, Beliefs and Behavior**

**and**

**A Simple History of Ideas in Health and Aged Care**

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# 1. Introduction

Over the years and during the study of corporate health and aged care I have adopted and used a number of simple concepts to help explain and understand what is happening. There is nothing novel or new in any of these.

These "constructs" relate to the way we handle ideas, the patterns of thinking we use to understand the worlds we live in. I have drawn them from many sources and all I have done is select those that seem most applicable to what is happening in the health and aged care debate today. There are of course many ways of understanding and these are simple ones.

This outline was developed as an introduction to my critique of the 2011 Productivity Commission Report entitled "Caring for Older Australians". It may be too theoretical for some and as it has wider applicability to the matters addressed on this web site I have decided to make it a separate documents that can be referred to.

# 2. A Theoretical Approach

### 2.1 World Views

Lets take the example of an old wooden chair. To one group of humans this may be a priceless work of art, representing a creative era in our history. To a different socioeconomic and cultural group, it is simply an old battered object to be sat on - and for their children it may be something to carve their name or draw on. To a tribal culture that squats and has never sat on a chair it would simply be firewood.

This rather mundane example simply makes the point that the significance of the chair in a human world depends entirely on the way we think about it. The way it is treated is a logical consequence of that.

The argument then is that the way the incapacitated sick or the frail aged are treated and the care they receive is closely tied to the way the views of the culture that they live in or the subculture providing care understands them and the process of caring for them.

### 2.2 Category errors and necessary conditions

Lets examine an elephant, a camel, a horse, a donkey, even a cow. All of these are animals that we can ride. They all have 4 legs and are mammals. We would laugh at the idea if someone were now to argue that because a mouse or a lion had 4 legs and were mammals we would be able to go for a ride. It's obvious to us that a mouse is too small and that a lion would turn around and eat us. The categories of size and ferocity were ignored by the argument. The necessary conditions for a ride of large size and of amenable temperament did not exist for the mouse or the lion.

This silly example is obvious but it is not always so obvious. Category errors and the absence of necessary conditions underlie many of the illogical things that we do.

The argument is that there are category errors that underlie the way we too often think and theorize, including the thinking and recommendations made by the

productivity commission? There are necessary conditions for the sort of competitive corporate marketplace, they are advising, to work that have not been met?

### 2.3 Belief and Ideology

The world we live in is extremely diverse, consisting of an infinite number of contexts and situations within which we as groups and individuals find ourselves and build our cultures and our lives. As a consequence we develop widely differing ways of understanding the world we live in.

These "beliefs" about the way things are may be based on logic and evidence but more often than not they are based on limited experience and our human need for conceptual integrity. To be effective we need a system of thinking that makes sense of our lives to us, so we seek and create explanations, initially tentative they become certainties as they are reinforced by events and accepted by others.

For the purpose of this discussion I will regard an ideology as a pattern of thinking or believing developed successfully within one set of contexts or one culture and which has been successful for a group of people there. It becomes an ideology when it is perceived by those who embrace it as having universal relevance, and so applicable to a number or even all situations. They use its success in one context as grounds for applying it to situations where it may not be applicable. To do so they ignore category errors and necessary conditions.

### 2.4 Meaning and Identity

As conscious thinking beings we humans have no choice but to "act in the world" and to build up a set of meanings and understandings that enable us to do so. The more successful we are in the world we live in, the closer we hold the ideas that make our world real and allow us to succeed there. The cohesion of the ideas we use and their utility for us, makes the world a stable place for us. Psychologically we need these views of the world to have broad applicability even when they don't. We become uncomfortable when we are faced by situations we don't understand and try to interpret them within our experience and current patterns of thinking.

The things we do and the patterns of thinking that make us successful are critical components of our identity, of who we are. This is a social phenomenon, reinforced and augmented by the social interaction we have with others, and by the culture we grow up in. We share meanings and this reinforcement allows us to grasp them and hold them ever tighter. We seek to apply them to as many situations as we can. In the modern era, media and marketing also play a profound and assertive role in oversimplifying and generalizing the way we think about our world.

(What I am saying here is related to the concepts of Nomos and Anomie, particularly as used by Berger in his analysis of religion.)

### 2.5 Dissonance

Because our actions and the thinking that underlies them are so much a part of who we are, events and ideas that contradict them can be very challenging and cause us mental discomfort ("dissonance" or "angst").

How we respond to this depends on multiple factors. While it can be a stimulating challenge to be confronted as we define our lives, it is more often experienced as a threat that puts in question who we are and everything that we have done. It may threaten our future.

Our thinking can be challenged to the extent that the world we live in becomes unstable. The meanings and understandings we use to give our lives equilibrium, are put in question. There are strong pressures to develop strategies to cope with this discomfort without changing our belief systems. This is particularly so when our future well being, and the position we have established in society will be compromised if we change.

Psychologists describe a number of strategies, such as rationalization, compartmentalization, labeling, ridicule and aggression that we employ to avoid directly confronting the contradictions in our lives. Typically the "self evident truths" on which beliefs are based are forcefully asserted and any challenge to their validity is derided. This is where the ideological beliefs are most vulnerable and believers most challenged.

In a complex world these strategies become important for our mental stability and for maintaining a secure identity. They can be essential in maintaining the integrity and cohesion of cultural groups. In general patterns of ideas will be adhered to and protected as long as they work for individuals or continue to function for the particular section of society. People may defend them with their lives.

Arguably we all employ these strategies to a lesser or greater degree. They are essential for maintaining our mental stability.

The problem is that this may be at the expense of others. It may disadvantage other individuals and other groups, particularly those who are weak and vulnerable. The consequences can be devastating.

### 2.6 Individuals

The variation among individuals is immense and the human possibilities even wider. The human parameter that interests me cuts across other parameters. It has reflectivity and uncertainty at one end and dogmatism and certainty at the other.

At one end the more we reflect on the complexities of the world, the more uncertain it becomes and the less clear cut do the meanings and the actions we take become. Its more difficult to be decisive and to lead.

Those at the other end of the spectrum make greater use of strategies to avoid confronting contradictions and reflecting on them. They have more definite views and can be more decisive and more convinced of their actions. They have no doubts about the decisions they make.

At this extreme lie the successful sociopaths whose ultimate reality resides in the statements they make and the things they do. Because they say them they are true. They have no doubts, are supremely self confident, and sometimes exceptionally charismatic.

We can argue that being decisive, and being able to persuade others, has considerable evolutionary advantage. It creates certainty and order. This beats disorder and uncertainty every time.

Where individuals reside on this continuum between reflectivity and dogmatism depends on their innate ability to tolerate dissonance and on the level of dissonance with which they are confronted at any one time. Most of us would move along this continuum at different times.

It is important to understand that this parameter is separate from intelligence, but it does influence the way we use our intelligence - to question, challenge and understand at one extreme and to rationalize and justify at the other.

Finally we might suggest that wisdom is the ability to navigate this continuum in such a way that reflectivity is combined with the ability to make decisions while acknowledging uncertainty, yet remaining credible and persuasive.

(These ideas were generated from Milton Rokeach's 1960 book "The open and closed mind". The recent interest by psychologists in the number of successful businessmen who can be classified as sociopaths is tacked on to this. )

### 2.7 Relevance

What I have done so far is create a number of "abstract constructs". We should not confuse them with ultimate reality. Their value is that they allow us to extract and grasp some facets of the complex world we live in and the complex animals we are. By doing so we can isolate and stabilize important factors. We can look at some aspects of the way this world works.

In this instance my argument is that they are all relevant to the way health and aged care is provided and the individuals that provide it. The health and aged care systems as well as the productivity report is a product of the world we live in. I want to use these "constructs" to show where and why that report is flawed and why there are dysfunctional and un-confronted contradictions at the heart of what the commissioners are advocating.

## 3. History of Health and Aged care

History describes the events of the past, the situations that existed and the actions of the individuals who made the decisions that affected the lives of other individuals and the course of events.

Of particular interest are the frames of understanding used by the different cultures and the individuals who belonged to them; the basis for the decisions they made.

The one thing that history tells us about the systems of explanation, and the way we think about things today, is that in time they will be obsolete. They will be subject to the same critical and often negative evaluations as those whose faults we see so clearly today. (eg. colonialism, apartheid, communism)

To understand where we are today we need to look at where we have come from. I have been directly involved in the changes in health care over the last 70 years and more recently of aged care. This is my interpretation of this history.

### 3.1 The beginning

The history of health care thinking and its offshoot aged care, goes back over 2000 years to the Greek Island of Cos. The physician Hippocrates recognized the inherent conflict between the financial and sexual interests of the physician

and the best interests of the patient. He understood the disparity in power that existed and the vulnerability of the sick or aged person.

The pattern of ethics Hippocrates developed, and these understandings, have formed the basis of a subculture that has survived to this day and on which modern social and medical ethics are built. At the heart of this is the acceptance of disparity in power, and the consequent ethical commitment to place the interests of the patient before all other interests. A complementary ethic is to serve society by placing its wellbeing ahead of personal ambition.

There was also a social ethic of fairness and equity, a commitment to provide care according to need and to charge according to means. This was built on a code of integrity between doctors on the one hand and members of the community on the other.

Developments, in health and aged care saw society itself become more involved, in caring for its members and in creating community based institutions for providing health and aged care. The ethic of care and the primacy of the interests of the person receiving care were adopted. The church, at the time was the vehicle for the promotion of social norms and values. It became the institution through which these services were structured and controlled.

This community/professional subculture is based entirely on a simple set of ideas and values. It has been one of the most enduring of subcultures in human history. It has been buffeted by the flow of events and a succession of ideologies, which it has survived.

The profession and the community are both a part of society. As such their members have embraced a succession of ideologies over the years. Many have been party to activities and practices that are directly in contravention of every ethic based on the Hippocratic tradition.

During my lifetime I have experienced and seen sections of the profession and large sections of the community embrace fascism, communism, socialism and apartheid. I have observed the way that they have responded to the intrinsic contradictions between these and their ethical traditions. On occasions both have been party to the systematic abuse of those their ethics should have protected.

During these periods some sections of the professions have maintained their traditions and their opposition to what was happening. As each wave of ideology has faded, the traditions have been reinvigorated and adapted to a changing world.

### 3.2 The rise of commercialism

As medicine became more sophisticated and so more costly, the commercial potential of medical services has been recognized. There has been progressive commercialization and so greater pressure on these traditions.

What we now call "Private medicine" was the traditional model of care. Doctors earned their living by charging a fee for their services but they were expected to do so within the constraints of the ethics of the subculture, with which they identified.

As medicine was commercialized in the 1950s and 60s, there were occasions when the trust of the patients that the doctor would put their interests ahead of the doctors commercial interests were sometimes abused. The profession was not good at addressing these transgressions.

My interest in the response of health care to social pressures started when I encountered situations like this and when doctors participated in the abuse of others under apartheid.

### 3.3 Making money available

As the cost of care increased many individuals could not meet them. A number of solutions extending from personal insurance, through medical aid to direct taxpayer funding were developed in different countries to make funds available to those who needed them and provide the money to fund care.

This made more money available. The payers were now separated from the coalface of care and the doctor was no longer the arbiter of equity.

The money available attracted commercial enterprises. Businessmen in the community and in the professions formed companies to exploit the potential for profit. Commercial interests separate from the profession and the coalface of care began to receive some of the payments.

Commercial considerations became increasingly important. Payment, previously closely tied to individual humane situations became an impersonal mechanism unconnected with the human frailty it served. The payers and corporate providers were no longer confronted by the human consequences of their decisions.

In spite of this the primacy of the medical ethic was not challenged at this time. Doctors continued to control the care that was provided. It was not considered appropriate for any organization whose primary focus was profit to be involved in the actual provision of care. It simply did not happen in countries outside the USA.

In the USA, in the 1980s, during the Regan administration, things changed. In the UK, Prime Minister Margaret Thatcher pursued a similar policy. Economic thinking in the Western world moved radically to the right. Until then the ideas that underpinned the market were considered to be the way in which business operated. During this period this market based belief system was seen to have universal applicability. It became an ideology.

The category errors and the necessary conditions for a competitive corporate marketplace to operate in areas such as health and aged care were ignored, as were over 2000 years of tradition and experience. Commercial enterprises, whose primary objective and responsibility was to create profit, not only entered health and aged care, but were seen to be the best way of providing this care. Older patterns of thinking were labeled as obsolete.

The vast profits generated by large corporations in the USA delighted shareholders and drowned the rational arguments of critical doctors like Professor Arnold Relman. The battle was won by financial success and not by rational argument.

Doctor's control over the money the businessmen wanted restricted the way big business generated profits. Regan's secretary of health, Joseph Califano led a concerted attack on the medical profession. They were blamed for the

escalating costs of health care and vilified in a number of ways. The market, the big "corporate providers" on the one hand, and the managed care groups on the other gained control over doctors income and their careers. This put them in a position to dictate the way health care was provided and they did so.

Not surprisingly the cost of health care in the USA continued to rise rapidly. It is by far the most expensive in the world. At the same time World Health Organization figures show that the USA has one of the worst overall standards of health care in the developed world. The worlds largest and strongest advocate for corporate health and aged care is its most economically inefficient. Health care remains very profitable and these failings are not confronted.

Health and aged care in the USA have been characterized by a succession of massive scandals in which large numbers of citizens were misused for profit and vast numbers of others were disadvantaged or fleeced.

The system has been dogged by a succession of massive fraud scandals. Health care has exceeded all other sectors in fraud settlements. Aged Care was not far behind. Its record for dysfunctional practices; for chasing after profitable elderly, while neglecting those who were less profitable; and for fraud rivals that in the rest of health care.

It is clear that these scandals and frauds were not isolated events. They were red flags to less flagrant but dysfunctional practices, a malaise across the entire sector. They were a consequence of the way the market operated. I will explore the reasons for this in a subsequent section.

This did not dent the vast profits made by the big corporations, the enthusiasm of the share market, corporate power, or the strong support that the perpetrators received from state and federal governments.

Australia was not immune from these developments. Home grown entrepreneurs were followed by a succession of multinationals. They enjoyed less success in this country although steady inroads were made.

The tipping point came after the election of the Howard government in 1996. They established the National Competition Council. Economic Rationalism became the official policy of government. All of society was required to conform. Doctors were directly in the firing line as they controlled the way money was spent.

## 3.4 Economic Rationalism in Australia

### 3.4.1 Health Care

As indicated before a number of Australian medical entrepreneurs formed companies during the 1980s but they were not well supported. Their financial plight threatened the private hospital sector. The market, supported by government, went looking for multinationals.

A massive US multinational entered Australia in 1991. Their exploitation of vulnerable citizens in the USA became an issue. Australian states all had probity requirements. Applicants for hospital licenses were expected to be "fit and proper" individuals who could be trusted to put the care for the vulnerable ahead of their own interests.

Although only Victoria had the legal backing to deal with multinationals, this expectation proved a major stumbling block to the company. This

together with a lack of support from the medical profession saw them depart in 1996.

After the Howard government was elected in 1996 the new health minister made his intentions clear to the medical association in Canberra. The president of the AMA made it equally clear at the same meeting that this did not have his support.

The matter came to a head in 1998 when AXA, a major health insurer and Mayne Health, Australia's largest hospital company attempted to entice and then force hospital specialists to enter into the sort of contracts that had crippled the health profession in the USA.

The medical profession, who where well aware of what had happened in the USA realized that this was not in their, or their patients', interests. They resisted threats by government to pass laws that would force them to sign these contracts. A clause in the Australian constitution prevented the minister from doing so.

Australia was threatened by two more giant multinationals, one of whom planned to enter aged care. One backed off when its massive frauds in the USA were exposed. The other was blocked by a probity review and was not strongly supported. It entered bankruptcy and never entered aged care.

The medical specialists used the independence they had preserved to good effect when Mayne Health, Australia's largest corporate hospital owner adopted the unethical US practice of favoring the admission of profitable patients at the expense of the less profitable. Specialists simply took their patients elsewhere. Mayne avoided bankruptcy by selling off its hospitals.

The health minister and the AMA president were soon trading lawsuits. His attempts to control the way doctors provided services led him into questionable practices and he finally departed politics under a cloud.

Corporate hospitals realized that they could not introduce commercial practices that impacted on the profession or their patients, without consultation, and agreement from the profession. Australian health care has consequently been protected from the worst excesses of corporate ownership.

After 1996 doctors were subjected to National Competition Policy. They were forced to abandon some of their ethical traditions, their professional cooperation, and some of their collegialism. Ethical traditions had required that commercial competition be less important than, and subservient to, cooperative effort to provide care and serve the community. These practices were seen to be anti-competitive and so illegal.

### 3.4.2 Aged Care

Aged Care, particularly nursing homes (now renamed residential aged care), differs from the rest of the health sector in that doctors do not play a critical role and have no power or control over the system. The principal carers are nurses or less trained nursing assistants. They are employed and controlled by the providers of health care. They are not in a position to control or influence the way the aged care system operates.

Aged care was commercialized more slowly than other sections of health care. It was finally converted from a cooperative community and church dominated service into a competitive corporate marketplace, attractive to investors, by the Aged Care Act 1997.

The money to fund this and to make it profitable for providers and entice investors was to come from the sale of the family home, the main asset of middle class Australia.

There was a violent community backlash against the forced sale of the family home. The government backed away and repealed this section of the act in 1998. This left the government as the primary funder of aged care. It was now both the funder and the regulator of the businesses that had helped to put it into power and to draft the new laws. It had to ration services in order to protect the public purse. The economic rationalist ideal of a free and competitive marketplace could not be fully achieved.

Since 1998 a succession of market focused inquiries have recommended that the wealth locked in citizens' houses should be tapped to fund the aged care marketplace. Governments did not have the courage to try this again.

With a rapidly ageing population and rising costs the pressure from the marketplace to tap into the family home has increased. The current labor government has been softening up the public to agree to their tapping into the family home.

In 2010 the productivity commission was given the task of finding a way of doing so, a way that could be sold to the public. As we will see its 2011 report does this.

Prior to 1997, providers of aged care were held to account. They were required to disclose how they spent government money and the number and type of staff they employed. Oversight was at a state level. States checked on failures in care as best they could. The corporate providers complained bitterly. This oversight was considered to be unnecessarily arduous and to limit the operation of the free market.

As the market was "liberalized", accountability in regard to how funds were spent and how nursing homes were staffed was removed. The regulation and oversight of nursing homes was taken over by the federal government. The probity requirements for nursing home ownership, about which the federal aged care department had previously boasted, were abolished. A corporate friendly "approved provider" system replaced it.

The 1997 aged care act was bitterly opposed by the opposition labor party. Government would have been politically vulnerable were objective evidence to emerge that their market reform compromised care. It is not surprising therefore that they did not reinstitute any objective measures of care but instead opted for a system of accreditation that had already failed to contain dysfunction in the USA.

Accreditation is a provider friendly system, based on the oversight of processes that are believed to improve care, assisting motivated nursing homes to adopt these processes. It is not on objective or even subjective way of monitoring care. It does not collect or quantify the actual failures in

care. It was designed to help providers to improve care by ensuring that they knew how to provide care but not to monitor that care or to regulate.

As a consequence there is no means of measuring whether accreditation is effective or of knowing what the standard of care in our nursing homes is. Recurrent claims to "steadily improving standards", or to "world class care" are simply wishful thinking or propaganda. There is no basis for them. They may or may not be true.

The USA did not go nearly as far in "liberalizing" its aged care marketplace. State oversight was retained. Some objective measures continued to be made, adverse events were quantified. As a consequence it has been possible for US citizens to get some information about the standard of care in nursing homes and to draw some conclusions from that information. Consumers groups and newspapers have been able to do so. Accreditation findings could be contrasted with the findings of state regulators, and have been shown to be wanting.

## 4. Standards of Aged Care in Australia

Much has been written and there has been a wide divergence of opinion as to how good our aged care system has been.

On the one hand there are the providers of care and the politicians. Both support their claims by pointing to the overwhelming compliance with the accreditation process. They accuse the press of sensationalism and claim that the recurrent scandals that have plagued nursing homes since about 2000, are isolated events and do not reflect overall standards of care.

On the other hand there are relatives, nurses and community groups who look at the multitude of press reports, and the recurrent scandals as red flags and pointers to serious deficiencies in the care provided. Older nurses returning to nursing after raising their families are appalled at what has happened to care in their absence. Academics who have tried to study aged care have reached similar conclusions.

Critics have been attacked and criticized because of their bias and lack of objectivity. Nurses who have attempted to blow the whistle have lost their jobs and been attacked and discredited. Relatives of residents are afraid to speak out lest their family member suffer the consequences. Many submissions to the productivity commission inquiry describe failures in care and/or widespread staffing issues.

For someone, who has watched exactly these sort of events play themselves out over and over again in the USA, it seems clear that across a significant section of Australia's aged care system, care is seriously deficient. Care is not what it should be. It falls far short of what Australians expect and deserve.

## 5. Structure of Aged Care

Any discussion of the impact of a competitive market on aged care is confused by the way Australians think about this as being between public and private. The critical consideration is whether the providers of care are there primarily for the benefit of the person they seek to help, or primarily there to generate a profit for themselves or somebody else.

In aged care profit and care compete directly for the same limited pool of money. The more care provided the less remains for profit. The more profit that is taken the

greater the cost cutting that has to occur. About 70% of the cost of care is staff salaries. The number, skills and motivation of staff is the primary factor impacting on care. The tensions that a strong focus on profits introduces into a system like this should be obvious. Disparity in power invites entrepreneurial exploitation.

Australians divide care into public and private but this gives a false perspective. Even the more useful terms for-profit and not-for-profit do not always clearly reflect the pressures in the system. Both these groups provide public and private care. The following classification attempts to make some sense of this.

### 5.1 Not-For-Profit

Groups that are or should be focused primarily on care include **government**, **community** and **church**. They focus on the needs of the community and provide most of the care to less privileged or remote groups. Factors distracting them from their mission include political and bureaucratic priorities, lack of community resources, local disputes, or religious beliefs that preclude certain activities.

The imposition of a competitive market introduces another distractor. It has forced these groups to bring in managers from the corporate sector and to adopt much of their thinking and many of their practices. Some of these may well improve efficiency but others challenge their primary focus on care.

While "competition" (as contrasted with cooperation) is now an important consideration for them, it is far from clear what they could possibly be competing for. They are there to provide the best care they can to meet the needs of the communities they serve with the resources they have. They might compete for government funding or even indulge in friendly rivalry to provide better care. Outside major centres, they might struggle to survive but no one is competing to replace them or to see if they can be more profitable.

Evaluations in North America over the years have indicated that in both health and aged care, not-for-profit organizations provide better care.

This focus on competition has engendered an entrepreneurial focus so that some not-for-profits (eg BUPA from the UK) have become global corporations building commercial empires across the world and chasing the money. They operate like for-profits and focus on the profits needed to fund that expansion by buying competitors. This blurs the distinction between for-profits and not-for-profits, making evaluation of the factors more complex.

### 5.2 For-Profit

This is a broad category with significant variations. They focus their efforts in central areas where there is wealth. They follow the money.

#### 5.2.1 Private for-profit

Private for-profit organizations are owned by individuals or smaller groups but are not market listed. They have a range of objectives. These extend from those with a strong commitment to provide care and simply support themselves while doing so, to those seizing the opportunity to make money. My impression from the studies I have seen in the USA is that some of these providers are among the best and some among the worst. This is what you might expect as their primary motivation is so varied.

#### 5.2.2 Market listed corporate for-profit

Market listed corporate for-profit organizations exist solely to make money for their shareholders. Their managers have a primary fiduciary duty to put the commercial interests of shareholders first. They enter aged care to make money. It is not surprising that reports in the USA starting in 1994 suggest that they breech care standards about 3 times as frequently as not-for-profit organizations, and are generally positioned among the poorer providers of care.

#### 5.2.3 Private equity

Private equity is a more recent development. These are groups that are not listed on the stock market so they are subject to less scrutiny. Those who invest in private equity accept greater risk in return for larger profits in a short period of time. The pressures for profit are even stronger.

In health and aged care private equity groups buy less profitable companies cheaply, cut costs and restructure to make them profitable enough to sell for much more than they paid. Potentially the greater pressure for profit, points to larger risks for the residents. There have been disturbing reports from the USA where a federal government inquiry into their involvement in aged care has been held.

## 6. Paradigm Conflict: The dynamics of the marketplace in aged care

I will look more closely at the necessary conditions for a market to operate and at their absence when I examine the report. At this stage I want to look at what happens when there are two conflicting and mutually exclusive ways of understanding what needs to be done there. Lets call them "paradigms".

As I indicated at the beginning of this review this situation usually causes dissonance (mental distress). One paradigm requires managers to do something that is in direct conflict with what the other paradigm requires. In aged care pressure for profit in the market paradigm dictates that profit be increased by reducing staff and deskilling. The community paradigm dictates that care should be improved by providing more and better skilled nurses and accepting smaller profits.

The situation in aged care is compounded in that competition is to make money and not to provide care. Success depends on competing successfully. Failure to do so will result in "corporate death" by bankruptcy or acquisition. In a sense it is a life or death situation for companies. The market paradigm is consequently far more powerful and demands acquiescence. People do what they must to survive.

The community on the other hand expects and demands that their care be given priority, although in aged care in Australia they have no way of knowing if that is happening. The provider of for-profit care has to say one thing to keep their custom but do the very opposite to succeed. If you compare the public statements and marketing material of the health and aged care companies with their reports to shareholders, this is readily apparent.

Real villains who deliberately deceive are few and far between. Most of us in this situation accomplish what has to be done by finding a way of dealing with the conflict, culling staff while at the same time believing that we are acting in the best interests of the residents we believe that we are serving.

If the company is going to compete successfully and if employees are to prosper in a company that is successful, then, to maintain motivation, to have a sense of social worth and to have standing in the community both must believe in what they are doing. The best examples of this (believing they are doing one thing, but actually doing something different and contradictory) can be found in the internal documents that became public in the court proceedings that followed the scandals in the USA.

Earlier I referred to the several strategies employed to decrease dissonance. I will use the common strategy of compartmentalization as an example. Here the two conflicting paradigms are kept in separate mental compartments and the conflicts are never confronted. The person acts out the particular pattern of thinking that is required for the moment and sees no conflict.

If the person is forced to confront the contradictions they are likely to resort to rationalization to justify their position. When this is challenged the response is to attack, ridicule or otherwise discredit the critic and when all else fails becoming angry. When this occurs within an organization (whistle blowing) the challenger may be isolated, ostracized and lose their job.

All of this occurs in the marketplace when there is an imbalance in the power and the credibility of the customer. When the customer has the knowledge needed to evaluate the service, as well as the credibility and power to force the issue then this sequence of events is curtailed if not eliminated. This is one of the necessary conditions for a market to work.

Customer power is the critical condition that makes a market work for individuals and the community. "Customer beware" matters and if a market in decrepitude is to work then the decrepit must not only "beware", but in this competitive jungle, they must have sharp teeth and the ferocity to use them. As we see, in the report, the commissioners' dental efforts, by providing more information, may restore a few old stumps but the ferocity is not there and the bite not painful.

Market failure due to customer factors is common. It lies behind most of a long list of Wall Street Scandals, and of the scandals surrounding financial advisors in Australia. It has been responsible for the exploitation and harming of patients in health and aged care.

Medical specialists in Australia retained their credibility under attack and their power when threatened. They used it when required, showing that they were the real customers of hospitals. Doctors in America lost their credibility under attack, and their power when they lost control of their careers and their incomes.

The problem with aged care is the lack of a powerful customer. The residents and their families lack power and knowledge. The community at large, probably the real customer, lacks the insight and interest. The minority that do understand and are interested lack credibility and power.

The criticism of the productivity commissions report is that they refuse to adequately confront the contradictions at the heart of this market. My particular interest in the report is the way they do this.

For more on paradigm conflicts in health care see
**"Belief versus Reality in Reforming Health Care"** Health Issues 2005, Number 83, pp. 9-13. http://corpmedinfo.com/jmwynne83.pdf

### 6.1 Who prospers

The last thing I want to look at in this introduction is the way this distorted marketplace selects some of its leaders.

I earlier referred to the personality parameter with reflectivity at one end and dogmatism at the other. Those at the dogmatic end of the spectrum are adept at coping strategies. They have all of the advantages in this sort of marketplace. They are adept at doing what has to be done and then developing a strategy for believing that it was not only justified but desirable. Some are highly intelligent and able to rationalize and then convince others by their conviction and force of character. Some are successful sociopaths.

It is hardly surprising that they prosper in this environment, become very credible. Because they can "do what its takes" without experiencing any doubts they make vast amounts of money, the measure of success. They are promoted and become authorities. These same characteristics also allow them to justify other practices that the wider public would deplore or that are illegal. They are particularly likely to foster and encourage fraud.

Because of their confidence, conviction, charisma and willingness to support political parties these individuals and their companies become highly credible and are accepted as authorities. They enjoy political influence and support. Their views are adopted

Their meteoric success frequently ends in tears all around. The "successful" corporate cultures that they create are infectious. Others emulate successful practices and adopt the rationalizations. These "successful" corporate cultures are far more durable than their creators and survive the scandals. The corporate offenders remain accident prone and at risk of re-offending.

If we examine the leaders of the most successful corporate health care giants in the USA and the many fraud scandals that engulf them we find that many of the leaders are positioned near the dogmatic end of the spectrum and some can even be called successful sociopaths. The Wall street corporate scandals are also populated in this way.

If we look at Australian health care we find people with similar characters. Although they have created problems, they have not been as successful as in the USA and have come unstuck sooner.

To explore this issue further see http://www.corpmedinfo.com/sociopathy.html